NAVAL MEDICAL CLINIC ANNAPOLIS

# CLINIC CRIER

Homepage - http://nmclanna.med.navy.mil

WINNER OF THE 1999 MHS CUSTOMER SATISFACTION AWARD

250 Wood Road,
Annapolis, MD 21402-5050

## From the Commanding Officer:
## CAPT Kathleen D. Morrison, MSC, USN

Dear NMCLA Family,

It almost seems like only yesterday that we were anticipating Y2K! Our reputation stands as a "can-do" and progressive command that achieves quality results, thanks to YOUR efforts and professionalism. Over the past year, we have used several opportunities to showcase the command, the staff and our contributions to USNA. You can be proud of your Navy Medicine legacy that is being nurtured every day. Our family of military (reserves too!), civilians, contractors and volunteers remain strong, and I see examples every day of your commitment to our award winning customer service. You are high quality professionals whose leadership has embraced teamwork and accomplished successful evolutions including:

### STRATEGIC GOAL 1.
### FORCE MEDICAL READINESS

- Streamlined I-Day immunizations process
- Completed 9 Industrial Health surveys at Annapolis Area Complex commands
- Initiated first phase of Annapolis Area Complex annual medical record verification
- Established Health Promotion Office in BH, and are finalizing our HP website

### STRATEGIC GOAL 2. PEOPLE

- 8 selected for C schools, 7 advanced and 3 promoted (plus 2 selects), we welcomed almost 40 aboard! ☺
- Numerous events and military ceremonies highlighted your personal and professional achievements with Ethnic and Navy Birthday celebrations, awards, published efforts, and certifications. Almost 50 awards were presented from Oct 99 to present.
- Adapted the first Leadership Definition and 5 Value Statements
- Completed several self-help projects allowing us to continue to preserve and maintain this historic facility; CBU 403 completed stairs and pharmacy walkway
- CFC Donations exceeded previous 4 years!
- About 90 students (residents, fellows, PT, PA, etc) rotated through our facility with a thumbs up on how well the health care team works together!
- NMCLA Color Guard presided at 23 ceremonies and has grown from 5 to 14 personnel.
- 93% personnel passed new PFA. (Initial reports anticipated up to a 30% failure rate Navy wide due to the increased standards.)
- Approx 140 customer compliments were received (letters, emails, etc); 60 of our customers also gave us improvement ideas.

### STRATEGIC GOAL 3.
### HEALTH SERVICES

- Successful Class 2004 I-Day,
- Streamlined PRECOMS 2002 process
- Coordinated most efficient service selection (Class 2001) documentation in years,
- Established our first Battalion Aid Station for Plebe summer with phenomenal results,
- Enhanced documentation for Heat Exertional Illness Clinical pathway
- Performed approx 225 orthopedic surgeries at Anne Arundel, Ft. Meade and NNMC
- Performed 135 MSTs (Sport, PEP, Marksman, Immunizations) totaling 2113 hours.
-

### STRATEGIC GOAL 4.
### INFORMATION MANAGEMENT

- Received recognition from REGION 1 for our preparation for PCMBN, MCP module implementation,
- Selected as Demonstration site for SPMS 2

### STRATEGIC GOAL 5.
### BUSINESS PRACTICES

- Refined Pharmacy Refill system reducing the patient dissatisfier waiting times
- Outpatient Visits increased by 3% to almost 92,000 during FY 00. Physical Therapy had the biggest increase in patient visits for FY00-19%.
- Improved patient access with diverse appointing schedule
- 6 Clinical Research projects with Sports Injury focus
- Approx 11,500 customers have chosen NMCLA as their Health care facility!
- Implemented new Command Support Crew Instruction with midshipman alternative berthing room and a corpsman on duty in Bancroft Hall.

Spearheaded PCMBN initiative with NMCLA

(continued on page 4)

VOLUME 1, ISSUE 6
DECEMBER 2000

**INSIDE THIS ISSUE:**



**SPECIAL POINTS OF INTEREST:**

*Prime enrollment* - ***11651***

***PCC - 3650***

***Pediatrics - 1076***

***Mil Med - 6925***

## Coming Soon!

**DECEMBER 2000**

| | |
|---|---|
| 14 | Resources Mgt. Open House |
| 15 | Training Standdown and Command Holiday Party |
| 22 | ESC Sponsored Open House |
| 25 | Christmas Holiday |

**JANUARY 2001**

| | |
|---|---|
| 1 | ***Happy New Year !!*** |

Published by
The Clinic Crier Staff
NMCL Annapolis
Editor:HMC Priscila Fabian, USN

# A Holiday Reminder

Contributed by
HM1 Larry Correa, USN

Alcohol is a depressant drug that affects the central nervous system. The chemical compound ethyl alcohol has the same sedative effect as tranquilizers and sleeping pills, and it is toxic. It can create physical tolerance (the need for increasing quantities to obtain the same effect) and dependence. Beer, wine, and "hard" liquor are all alcoholic beverages. A 12-ounce beer, five ounces of wine, a nine-ounce wine cooler, or 1-½ ounces of liquor all contain approximately the same amount of alcohol (0.6 ounces).

The Navy defines alcoholism as, "disease characterized by physiological and/or physical/physiological dependence on alcohol." It continues the definition as "clinically defines as a cluster of cognitive, behavioral, and physiologic symptoms that indicate the person has impaired control of alcohol and continues use of the substance despite adverse consequences." The American Society of Addiction Medicine and the National Council of Alcoholism and Drug Dependence jointly define alcoholism as " a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations and the disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use alcohol despite adverse consequences, and distortions in thinking, most notably denial."

There is a variance among alcoholics: They have different drinking patterns (episodic, binge drinking, daily drinking, etc.), different choices of alcoholic beverages ("hard" liquor, wine, beer, etc.) and different quantities consumed ( a "few sips," several six packs, a fifth a day, a few glasses of wine with dinner, etc). Focus on the disease should not be on the differences but on the fact of uncontrolled drinking despite the consequences.

There are many "theories" of the cause of alcoholism. One theory, diminishing in popularity, is that alcoholism is a "moral weakness" –that the alcoholic could stop drinking if he or she "would just use a little willpower." Other theories regarding the cause of alcoholism include:

- That anyone who drinks enough over a long period of time can become alcoholic.
- That alcoholism is an environmental product, influenced by one's surrounding. These are areas of the country where drinking is much more acceptable than in other areas; and, therefore, more drinkers can be found there. There are also occupation which appear to attract heavy drinkers. These include popular musicians, poets, novelist, salesmen, career soldiers and sailors, and coal miners.
- That alcoholism is caused by an individual's "allergy" to alcohol.
- That this person metabolizes alcohol differently than others.
- That it is caused by either a deficiency or excess of neurotransmitters in the chemical make-up of the brain.
- That the disease is genetically influenced. Research has made it increasingly clear that the genes people inherit can contribute to the development of alcoholism. In the last few years, studies have persuasively demonstrated that approximately one half of all alcoholic persons have inherited a genetic predisposition-or susceptibility- to the disease. Studies of twins and adoptees have shown that children who have a biological parent who is alcoholic are four times more likely to develop alcoholism than the children of non-alcoholics are. For sons of alcoholic fathers, the risk is even higher. This is true regardless of the environment in which they are raised.

The disease of alcoholism may be compared to that of diabetes—while the individual is not responsible for developing the disease, he or she is responsible for carefully following a treatment program once they know they have it.

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# Are We JCAHO Ready?

This is #5 of the standards and they address the **Continuum of Care.** This is a very difficult set of standards to get our hands around and one that can be very problematic when our patients have to go to other places for the care they need. Our patients receive a range of care in multiple settings from multiple providers! It is extremely important that we integrate the settings, services, providers, and care. This makes up the **Continuum of Care** = matching an individual's needs with the appropriate place and practitioner.

There are only eight standards in this chapter but they may very well be the most important when it comes to caring for the patient.

The services that we provide must be consistent with our mission, the population we serve and our capabilities. When the patient requires treatment or evaluation that is not available here, then arrangements are made for transfer, referral or consultation at another site. Care must be coordinated among providers and the services flow continuously from assessment through treatment and reassessment.

This is not a matter of shifting responsibility of care. We are responsible to follow those patients going elsewhere and obtain any information gathered at the other site so that our own provider here has full knowledge of that information.

Eva Miller with Karen Coffman, Goal leader

A lot of progress has been made to obtain information on our patient going to the local emergency room. Our visiting specialist program with Bethesda has helped in the coordination of care for our patients. The command is considering a Nurse Case Manager position to assist the staff in coordinating care of more complicated patients.

Test your readiness on the Continuum of Care with these questions:

- How do patients assess your clinic? Is that in writing?
- How do you let patients know how to assess your care?
- How do you ensure your patients receive continuing and appropriate care?
- How is care communicated between provider and referring provider?
- Is care denied to patients for any reason?
- What resources do you have to assist you with continuity of patient care?
- What is the average length of time before a patient can get an appointment?
- What do you offer if the patient has an urgent need?
- What is done if the patient needs after hours care?
- What is your procedure if the patient fails to keep an appointment?
- What is the procedure if a patient requires admission for inpatient care?
- What information do you provide to patients before they obtain other care?

The goal leader for this set of standards is Karen Coffman, Managed Care Department. This department labors long and hard to assist in getting the information on our patients when they are elsewhere. Rita Davis, Pre-Coms office, works diligently to maintain continuity of care for Midshipmen who require consultation/referral to other facilities.

Each of us has the responsibility to help educate our patients on the correct process for obtaining care and making sure the information we give out is accurate and up to date. Evaluate your department policies on coordinating care. Processes need to be in place to ensure a continuum of care.

## COMMAND MASTER CHIEF'S CORNER
## HMCM(AW/SW/NAC) RONALD RANG, USN

Hello, I'd like to introduce myself to you. I'm Master Chief Rang, your new CMC. I have a varied background. I've been attached to aviation squadrons, deployed onboard aircraft carriers as well as destroyers and frigates. I've even been stationed with the Marines once or twice. I could have retired last September, but the detailer offered me orders to NMCL Annapolis, and that just sounded too good to pass up because I had heard such good things about this clinic and the people that man it. After observing clinic operations for the past two weeks it all seems true. My basic philosophies are simple. If it weren't for junior enlisted and junior officers, there wouldn't be a need for Master Chiefs. Take that line of reasoning a step further and it seems I work for you just as much as you work for me. My only reason for being here is you, to help you develop professionally, to train you and make you competitive for advancement, to mentor you in your career choices and to just make you better well rounded Corpsmen. I look forward to working with you all, and I am especially proud to be a member of the Annapolis healthcare team.

Submitted by:
LT Andrea Petrovanie

**Referrals vs. Prior Authorizations**

A referral is an order from a Primary Care Manager (PCM) for a TRICARE Prime patient to receive specialty healthcare from another provider. Without a referral, TRICARE Prime beneficiaries will pay for those services under the Point-of Service (POS) option, which includes an annual deductible and a substantial cost-share.

Prior Authorization is a process that:

- Determines if the service or care is a covered TRICARE benefit
- Ensures that all TRICARE rules have been followed
- Documents the approval or denial of the service or care
- Notes on the patient record to pay the claim for authorized services.

To make sure you receive the most appropriate care in a timely fashion:

1. Always visit your PCM before seeking specialty care.
2. Receive a referral from your PCM for specialty Care.
3. Your PCM will obtain prior authorization from Sierra Military Health Services, Inc. (SMHS) for the care.
4. Call SMHS to book your specialty appointment 24 hours after you see your PCM. Call (888) 999-5195 and select the option for scheduling appointments.
5. If you make your own appointment, be sure to call Sierra back to give them the appointment date and provider name so your claim will be paid correctly.

**Claims Information Made Easy**

Palmetto Government Benefits Administrators (PGBA) has recently developed a web site for TRICARE beneficiaries at www.myTRICARE.com to provide beneficiaries and providers with claims status. DEERS eligibility, benefit explanations, provider directory, and forms. It also has Frequently Asked Questions and an Ask Customer Service e-mail feature. PGBA processes claims in Regions 1,2,3,4,5, Central, 9, 10 and 12 serving 3 million beneficiaries in 46 states. If you want quick answers about TRICARE at your fingertips try utilizing www.myTRICARE.com today.

**TRICARE Question and Answer**

Question: What medications are available through the National Mail Order Pharmacy?

Answer: The NMOP is for prescriptions that you take on a regular basis, such as medication to reduce blood pressure or treat asthma, diabetes, or any long-term condition. It is not intended to be used for acute medications like antibiotics.

Sierra Military Health Services (SMHS) CME Program

Future lectures and symposiums have been planned across Region I on a myriad of topics. The events will be posted on the SMHS Web site, www.sierramilitary.com. In addition, special mailings targeted to various locations will be distributed to providers.

If you would like further information about the CME initiative, please refer to Sierra's web site or you may contact the Medical Director of Quality Improvement, Dr. J. Ramsay Farah at 1-410-864-2621.

**Emergency Room Guidelines for Primary Care Managers**

The term "medical emergency" is defined by TRICARE as "the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition listed in the current edition of the International Classification of Diseases (Clinical Modification) that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative effort to relieve suffering"

If a beneficiary experiences a life-threatening emergency, they should obtain emergency care from the nearest appropriate medical facility. Prior authorization is not required. Beneficiaries are advised to consult with the PCM first in non-emergent situations. This allows the PCM the opportunity to assess the patient and to advise the patient of the appropriate course of treatment.

Patients who seek emergency care while they are outside of Region I area should be instructed to obtain treatment from the nearest emergency room and to notify their provider of any significant occurrences.

Please remember to always input a CLN order whenever a Prime beneficiary is referred to another facility. This includes Bethesda, Walter Reed, Anne Arundel, and others.

# Techniques to Help Patients Learn

Educating patients is a key part of the health care team's role in an ambulatory care setting. A first step in the education process is to assess patients and families for their motivation and willingness to learn. In fact, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) looks for documentation of this during site surveys. The following are some tips that will help patients learn self-care:

- Make sure the patient is ready and receptive to learning. Listen carefully, as patients will let you know what they need to learn. The questions they ask reveal that they are willing and indicate the topics they are most interested in. Make sure your teaching methods are age-appropriate.
- Different people have varying needs for detail. It is important to meet each individual's need while at the same time, meet your own teaching goals. Also, keep in mind that the patient is viewing their care from a different perspective, and don't hesitate to put yourself in his/her shoes.
- Teach to solve problems. Focus on behaviors and skills rather than general information. Include whatever general information is necessary to provide the rationale for the behaviors and skills so they make sense.
- Overcome barriers to learning. Sometimes such barriers are merely mismatches in what the learner wants to know and what you want to teach. One strategy is to deal with the learner's issues first. Because you are addressing first what the patient is most concerned about, this satisfies their needs and helps build your relationship. For example, a patient or family member dealing with the emotional response to a new diagnosis or prognosis needs to work through their feelings. His/her ability to focus and remember new information will be limited. Give your learner permission to experience feelings and

Continued on page 4

## Congratulations!

**NOVEMBER 2000 Awardees**

**(L-R) Ms. Karen Coffman, LCDR R. Ebel, LTJG N. High, HM1 Davis, HN J. Palacios, LT K. Elder, HM3 R. Vega, Mr. Robert Radford**

## Hail!

LCDR Mundt—DIR, Cust.Svcs.
HM2 C. Moncrief - X-Ray
HM3 B. Dillie - MilMed
HM3 A. Waterman - Pt. Admin
HN C. Boldt - OpMan
HA D. Peck - Pharmacy
HA S. Barnwell - MilMed

## Farewell!

LCDR W. Brown - CivLant
LTJG N. High - BMC Little Creek, VA
LTJG S. Wang - USNH Gtmo Bay
HM1 B. Holloway - CivLant
HM3 J. Disney - USNH Roosevelt Rds.
HM3 W. Graves - C School
HM3 A. Ngolo - USNH Rota Spain
HM3 S. Pierce - C School
HM3 F. Strasserking - C School

Navy Football game ball presented by Jack Lengyel to NMCL

*Holiday reminder…..continued from page 2*

As with other chronic diseases, the symptoms of alcoholism may "go away" with treatment, but the disease is still present in a controlled form. In other words, the disease is in remission as long as the alcoholic doesn't use alcohol. Although incurable and potentially fatal, it is important to remember that alcoholism is also among the most treatable of all chronic diseases.

Anyone can be an alcoholic—male or female, rich or poor, young or old. Alcoholism is an equal opportunity disease.

*Techniques to Help…..Continued from page 3*

provide emotional support. When your learner is emotional, help him/her regain a sense or control. Provide information clearly in writing, offer the phone number to someone they can call if they have questions, and supply information on resources or support groups (London 2000).

- Patients and families need to be aware of the impact a diagnosis will have on their daily living. Their awareness and understanding need to be raised before they can learn effectively. They need to be fully informed on symptoms, medications, and any lifestyle changes they need to make to stay healthy.
- Show patients how learning helps improve the length and quality of life. Then teach the skills and behaviors that will help them follow through.

Adapted from: London, F. (5/11/00). Available:http://www.nurses.com

*CO's …..continued from page 1*

- being selected as one of the first MTFs in Region 1 "ready to go"
- NMCLA and USNA coordinated the first ever Navy-sponsored PRK program for Midshipmen.
- Integrated TRICARE Service Center (TSC) into MTF highlighting the "one customer; one health care system."

This is just a small representation of what you do every day to *provide health services to the Brigade of Midshipmen, active duty and all others entrusted to our care.*

Welcome to our new Command Master Chief, HMCM Ronald Rang! His comprehensive clinical, administrative, and leadership background is a fantastic addition to the command! I want to thank HMCS Steve Rogers for his leadership and command support for the past 6 months. HMCS Rogers will join the Managed Care staff as we enhance our TRICARE education and awareness programs.

As with any family, some of our time has been spent on challenges and adapting to changes. Thanks for your continued commitment to the customers (internal and external!) who see the value of Navy and military medicine. More changes await the command as we prepare for 2002 JCAHO/IG inspection, and coordinating space /relocation design plans, implementing PCMBN, reassessing appointments system, and designing TRICARE FOR LIFE (for beneficiaries who are over 65). Thanks again to each one of you for all that you do, for the long hours and for the dedication, pride and professionalism. *Use what talents you have; the woods would have little music if no birds sang their song except those who sang the best* (From my email QUOTE OF THE DAY). All of you play an important part of our many successes--**You are a phenomenal health care team with unparalleled energy, and leadership.**

Enjoy the holiday season, your family and friends; pace yourselves ☺! Blessings/CO